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BRITISH COLUMBIA CORONERS SERVICE
ANNUAL REPORT 1999

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BRITISH COLUMBIA CORONERS SERVICE

1999 ANNUAL REPORT

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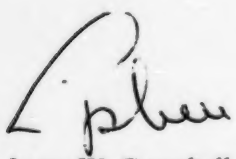
September 2000

The Honourable Andrew Petter
Attorney General
British Columbia

Sir:

I have the honour to submit the 4th Annual Report of the Office of the Chief Coroner for the year beginning January 1, 1999 and ending December 31, 1999.



Larry W. Campbell
Chief Coroner
Province of British Columbia

BRITISH COLUMBIA CORONERS SERVICE
1999 ANNUAL REPORT

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BRITISH COLUMBIA CORONERS SERVICE

INTRODUCTION

The Office of the Chief Coroner of the Province of British Columbia is responsible by statute (Coroners Act) for the investigation and certification of all unnatural, sudden and unexpected/unexplained or unattended deaths.

HISTORIC DEVELOPMENT

The Coroners system is the oldest legal, investigative and judicial system in British Common Law. Its origin antedates Magna Carta. Although its actual beginnings are somewhat obscure, most authorities relate it back to the English Articles of Eyre in 1194. The Coroner was known as a "Keeper of the pleas of the Crown", the term 'Coroner' evolving from 'Crowner'.

The former utility of the Coroner as a protector of Crown revenue, or as an agency for bringing suspects to trial, is no longer a consideration. However, what does remain constant in the face of this evolution is the continuing concern with the fact of death and the unchanged interest of the public in the protection of its members. The death of a member of society is a public fact. The circumstances that surrounded that death, and whether it could have been avoided are matters that are of interest to all members of the community. In this sense the Coroner exists to provide a truly public service, both individually and collectively.

Each province and territory in Canada currently operates its own sudden death inquiry system. In British Columbia prior to 1972, Coroners were judicially independent, common-law officers, who executed their duties as they saw fit. Service delivery was varied and the direct involvement of Coroners in their field work was minimal. In 1972 the government examined the court system. This review included the Coroner's Courts at Vancouver and New Westminster which had been operated by those respective municipalities. By 1975, the provincial government had taken over the operations of all the courts, including facilities and staffing.

In its continued desire to provide quality court services in the province, the government of the day studied the existing Coroner systems in other provinces and some states in the United States. The Ontario legislation was copied virtually verbatim, except for the requirement that Coroners be medical practitioners. The legislation was proclaimed in 1979 and the first Chief Coroner was appointed. Objectives in 1982-83 included improving the quality of Coroners' investigations and forensic medical investigations; improving the quality of judicial decision making in Coroners' inquests and inquiries; and improving record keeping and access to recommendations and their follow-up. The Service then developed de-centralized forensic pathology and toxicology and in-house training capabilities.

Emerging from this, three basic principles are manifest in the BC Coroners Service:

1. It is a fact-finding, not a fault-finding agency;
2. It is an independent service for the people of the community; and
3. It serves firstly the deceased and relatives and friends of the deceased; secondly, society as a whole; and thirdly, government agencies and other organizations.

Two major program areas, investigative and judicial, serve the primary mandate of the Coroners Service; the prevention of death.

ORGANIZATIONAL STRUCTURE

For organizational, budgetary and administrative purposes, the B.C. Coroners Service, falls within the Ministry of Attorney General's vote. The Chief Coroner, whose office is located in Burnaby, supervises the Coroners Service. There are eight regional offices, each headed by a Regional Coroner who is directly responsible for all Coroners' activities within his/her region. Regional offices are located in Victoria, Nanaimo, Vancouver, New Westminster, Abbotsford, Kamloops, Kelowna and Prince George.

In 1998, the Coroners Service had 38 full-time employees of whom 21 functioned as full-time Coroners. There were 120 appointed fee-for-service Coroners who provided much needed services to local and sometimes remote communities.

During the course of an investigation, establishing the means of death is more than simply determining the medical cause of death. The question of why the individual died mandates a careful examination of the circumstances leading up to the death. To assist the Coroner in carrying out this function, professionals or a team of professionals may be assigned to a case. The following special areas of investigation are primarily provided on a fee-for-service basis:

PATHOLOGY

The authority to order an autopsy is an absolute power that the Coroner must possess if the Coroners Service is to be effective. In deciding whether or not an autopsy is required, the Coroner must deem it necessary in order to determine the precise cause and manner of death. The autopsy must be considered to be in the public interest. In general, if a reasonable and probable cause of death can be deduced on the basis of the decedent's medical history, the circumstances surrounding death and a careful examination of the body, an autopsy may not be necessary for the Coroner's mandate.

The forensic autopsy is a very specialized autopsy, performed for special reasons. There is a great difference between a hospital autopsy and a forensic autopsy. Hospital autopsies are directed towards substantiating the accuracy of a diagnosis and therapy instituted during the course of an illness, as well as determining the immediate cause of death. The Coroner authorizes a forensic, or medico-legal autopsy, to determine the cause of death where it cannot otherwise be determined; to collect evidence from the body to document findings useful in clarifying time and circumstances of death; and, finally, to obtain evidence aiding in the identification of the body.

The Coroners Service investigates approximately 9,000 deaths per year in the province. Autopsies are ordered by the Coroner in approximately 30% of all cases reported. In British Columbia, the Coroners Service retains the services of pathologists who conduct medico-legal autopsies on a fee-for-service basis.

TOXICOLOGY

In conjunction with the medico-legal autopsy, Coroners authorize toxicology testing where it is required to establish or confirm the cause and manner of death. For the most part, toxicology testing is provided on a fee-for-service basis at the Provincial Toxicology Centre, an accredited laboratory located at Riverview Hospital in Port Coquitlam, B.C. In cases also under criminal investigation, toxicology testing is conducted by

the RCMP Crime Laboratory. To a lesser degree, some toxicology testing is performed at regional hospitals.

Forensic Identification Unit

This unit provides province-wide support to investigative coroners who require assistance with recovery of human remains that have been extensively compromised, difficult identifications, and the investigation of historic unidentified cases. The Forensic Unit co-ordinates forensic services in the areas of: archaeology, botany, entomology, anthropology, osteology, odontology, radiology, and DNA.

Medical Investigations

When Coroners' cases involve complex medical facts, registered nurses and occasionally medical doctors are assigned to review medical charts and interview persons who cared for the deceased. The information collected establishes the factual chronology of events to assess concerns, to develop recommendations and to prevent future deaths. The medical investigator prepares a specialized summary investigative report for the Coroner.

Behavioural Investigations

The Chief Coroner also retains behaviour analysts with backgrounds in psychology and social work to assist Coroners in cases where it is difficult to determine whether or not the incident was a suicide, accident or homicide. These analysts can also help in answering the question of WHY in known suicide cases. Behaviouralists focus on the questions of WHY and on PREVENTABILITY.

Coroners Act and Notification Requirement

Section 9 of the Coroners Act sets out the requirement for reporting a death to the Coroner. This section of the Act requires that a person shall immediately notify a Coroner or a peace officer of the facts and circumstances relating to a death where he/she has reason to believe that a person has died under circumstances where an investigation may be required. The Act specifically requires the reporting of violent, unexplained or sudden/unexpected deaths; deaths in custody; and deaths of persons to whom the Mental Health Act applies.

The Coroners Service is responsible for the investigation of all reported deaths in order to determine for each case, the identity of the deceased and the facts as to how, when, where and by what means the deceased came to his/her death. The system, therefore, is a vital part of law enforcement in initially determining whether such deaths are due to natural causes, accident, suicide or homicide.

The purpose of the Coroner's investigation has changed over the years. Previously, the major emphasis was directed towards the investigation of the actual medical cause of death to the exclusion of almost all other aspects. Now, the medical cause of death is only one of many factors to be considered. Often, the non-medical factors causing death are equally important.

When a death is reported to a Coroner, an investigation is commenced immediately with the focus on determining, as provided in Section 27(1) of the Act, who the deceased was and how, when, where and by what means death occurred. In conducting such investigations the Coroner has extensive authority to collect information, conduct interviews and seize

documents or other materials. In this regard the Coroner may rely on information received from other agencies such as the Workers' Compensation Board in industrial-related deaths or from the local police regarding deaths that may be crime-related. The ultimate objective is to undertake a thorough investigation so that the requirements of Section 27 are fully achieved. As some reported deaths involve elements of criminality, the investigation sometimes involves a combination of Coroner and police responsibility and requires a close liaison between the two agencies.

INQUIRY VS INQUEST

Coroners' investigations may be concluded by one of two procedures. The most common approach is for the Coroner to conduct an Inquiry and prepare a report for the Chief Coroner as provided by Section 20 of the Coroners Act. A Coroner's Inquiry is a quasi-judicial process conducted without a jury, by the Coroner. The Coroner interviews witnesses as required and reviews all investigative documents gathered from other agencies and then determines the facts. The Coroner's findings and recommendations are reported in a Judgement of Inquiry. This report will outline the factual circumstances relating to the death and determine the medical cause of death as well as classifying the death as natural, accidental, suicide, homicide or undetermined. Recommendations, where called for, are made to specific individuals and/or agencies, suggesting changes or improvements be made so that similar deaths or injuries can be prevented.

The remainder of investigations are concluded by an inquest, a quasi-judicial hearing held in an open forum with witnesses subpoenaed to testify under oath before a jury of five persons. An inquest is not a forum to resolve civil disputes or to conduct prosecutions. An inquest is not a trial and a Coroner is not a judge. The proceedings are investigational as opposed to accusatory or adversarial. Thus, there is no "accused" or "defendant" and no "parties" or "lis". There are several reasons to hold an inquest. Section 10 of the Act makes it mandatory to hold inquests into deaths of persons in police custody. Section 18 provides for the calling of an inquest when the Coroner determines it to be "necessary". Section 21 provides that a Coroner conducting an inquiry may, for reasons specified in Section 21, change the inquiry to an inquest and summon a jury for that purpose. Over time these latter two sections have been generally interpreted to call for an inquest because of :

1. serious concerns of the public or next of kin;
2. the refusal of a witness to voluntarily provide evidence to a Coroner conducting an inquiry;
3. agencies, institutions and interest groups legitimately pointing out concerns worthy of public focus.

The Attorney General may also, under special circumstances, direct an inquest be held as provided in Section 23 of the Coroners Act.

Inquest proceedings begin with the Coroner explaining to the jury their mandate and their responsibilities under the Coroners Act. The Coroner reviews applicable sections of the Coroners Act for the information of the jury and gives a short summation of facts relating to the death. Witnesses are then called and examined by Coroner's Counsel, the Coroner, members of the jury and persons granted standing. Persons are given standing if their interests may be affected by evidence called. They, or their representatives, may participate fully in the inquest by asking questions and calling evidence. Once all the evidence has been given, the Coroner adjourns the court and prepares a summation or overview of the evidence

presented. The hearing is then reconvened and the summation given to the jury. The jury then prepares its verdict which may be unanimous or by majority. The verdict and findings must not make any finding of legal responsibility or express any conclusion of law.

The Coroners Act provides no power to order change. The Coroner, however, submits the jury's recommendations to the Chief Coroner for dissemination to appropriate persons, agencies and ministries of governments. The jury recommendations must be lawful and are expected to be relevant and reasonable.

Coroner and Jury Recommendations

The mandate of the Coroner is to determine the relevant facts and, where appropriate or feasible, to make recommendations so that a similar death is less likely to occur in the future. Coroners' recommendations flow directly from the circumstances of individual deaths.

Although recommendations from either a jury or Coroner are generally viewed as compelling, the Coroners Service has no statutory authority to order change or to ensure that the recommendations will be carried out. Despite the lack of legal enforcement powers, the Coroners Service is successful in having most of its recommendations considered and acted upon.

On average, approximately 2500 recommendations are forwarded to various agencies in a year. The majority of responses received are either positive, under active consideration, or acknowledged as already being in place. As a direct result of Coroner and jury recommendations, policies and practices have been altered, more monitoring has occurred, and greater care and attention paid to altering conditions which might cause injury or death in the future.

New Legislative Amendments

Recent legislative amendments to the Coroners' Act:

1. Repealed the s. 9(2)(a)(i) provisions requiring that ALL deaths in community care facilities be reported to the Coroner. It is no longer a requirement that ALL deaths that occur in a Community Care Facility be reported to a Coroner. All deaths must now be reported to the Community Care licensing authorities. It is still a requirement that all sudden and unexpected deaths be reported to a Coroner.
2. Eliminated the mandatory s. 10 requirement for an Inquest in all custodial deaths and allowing discretion to proceed with an Inquest in these circumstances. It is no longer a requirement under s. 10 of the Act that all deaths that occur in custody have a mandatory inquest. It is now mandatory only for deaths that occur in a police prison or lockup or while in the actual custody of a police officer. Natural deaths that occur in a correctional facility can now be concluded by a Judgment of Inquiry. It remains mandatory to report all custodial deaths.
3. Formally provided a Coroner with the power to make an exhumation during an investigation. A coroner now has the statutory power under s. 15 to enter a cemetery and disinter a body. Prior to the amendment, exhumation power was derived only from common law practice.
4. Provided the Chief Coroner with discretionary powers to re-open an investigation after final completion of an Inquiry. Under s. 20, the Chief Coroner may now order an Inquiry re-opened, but can only do so if there is new evidence that is substantial and material. Previously, only the Attorney General had the power to order a new Inquiry.

Statistical Summary of Deaths

Statistical Reporting

The Coroners' Case Management System, CCMS, is an on-line Oracle database that maintains information on all reported deaths in British Columbia.

CCMS was developed in 1992 to assist in tracking and summarizing case information and is used for two main purposes, facilitating enquiries and statistical reporting of deaths. This statistical reporting is accomplished by the use of a coding system which is based on definitions adopted from the World Health Organization's International Classification of Diseases.

Cause of Death Codes

The primary definitions consist of the CAUSE OF DEATH and the MEANS OF DEATH: "CAUSES OF DEATH are all those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced the injuries."

The " UNDERLYING CAUSE OF DEATH OR MEANS OF DEATH is (a) the disease or injury which initiated the train of events leading directly to death or (b) the circumstances of the accident or violence which produced the fatal injury."

For the purpose of preventing death, it is vital to capture the precipitating event or Means of Death to provide researchers with meaningful research data.

Vital Statistics

The Vital Statistics Act requires that a Coroner or physician provide a Medical Certificate of Death for each death in British Columbia. The certificate is filed with a District Registrar of Births, Deaths & Marriages within 48 hours of the death. The funeral director, or person acting as such, is required to complete the Registration of Death, collect the Medical Certificate of Death and file both with the District Registrar. If the cause of death cannot be determined within the time required, the Coroner provides a provisional certificate that is later updated with the appropriate cause of death information.

Besides requiring this information for official records, the Division of Vital Statistics Research Branch utilizes mortality data for various aspects of health planning and education. They produce and disseminate relevant measures of health status, thus providing valuable information to health care researchers, planners and providers alike.

Classifications of Death

As of October, 1993, all deaths reported to and investigated by the Coroners Service have been classified, for statistical purposes, into the following five categories:

- A **Natural** death is one primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors;
- An **Accident** is a death due to unintentional or unexpected injury. It includes death

resulting from complications reasonably attributed to the accident;

- A **Suicide** is a death resulting from self inflicted injury, with intent to cause death;
- A **Homicide** is a death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame;
- An **Undetermined** death is defined as one which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

The Coroners Service maintains a separate category, referred to as a Non Coroners Case. A Non-Coroners Case is a natural death where none of the criteria of Section 9 of the Coroners Act are met. Following a brief investigation, the Coroner may conclude the case if a doctor has signed the Medical Certificate of Death or the Coroner may sign the Medical Certificate of Death if he or she is satisfied that the death is natural and consistent with known medical history.

Injury Prevention

The Coroners Service files are being used by a variety of agencies to collect valuable research data. The Coroners Service facilitates this research to ensure deaths in certain categories are collectively reviewed so that provincial and/or federal accident/suicide and injury prevention strategies can be adopted. These agencies are vetted by the Coroners Service and sign a research agreement, which ensures security and confidentiality in collecting only the necessary demographic information.

The following agencies make use of Coroners Service files, on an annual basis, for their injury/death prevention strategies:

Red Cross

The Canadian Red Cross and The Royal Life Saving Society Canada have combined efforts to work with communities across B.C. and the Yukon to reduce the number of water-related fatalities and injuries. These agencies produce a joint provincial summary of drownings in BC and the Yukon. The Coroners Service files provide the necessary data to allow these agencies to fulfil their role in educating the public and to work with the injury prevention community in reducing injuries and death due to drowning.

Traffic Injury Research Foundation

The Traffic Injury Research Foundation of Canada (TIRF) has used Coroners Service files to compile data on alcohol-use related to motor vehicle fatalities since 1974. A fatality database is maintained for all provinces across Canada. This database provides a comprehensive source of objective data on alcohol use among persons fatally injured in motor vehicle accidents. It is a means of monitoring changes/trends and is a valuable tool for research on alcohol-impaired driving.

University of British Columbia Mental Health Evaluation & Community Consultation Unit (MHECCU)

The MHECCU at the University of British Columbia and the Coroners Service have a unique partnership which supports the development and maintenance of a provincial database on suicide occurrences. The MHECCU program provides provincial leadership, information/research findings, and consultation and support to community partners throughout the province. The goal is to facilitate the development of a comprehensive approach to youth suicide prevention, reflecting the needs and priorities of local communities throughout B.C.

Coroners complete a summary form on every suicide in B.C. This information is consolidated and maintained in a provincial database by the MHECCU program. Their goal is to produce periodic reports summarizing the psycho-social information for all completed suicides in BC. This report is distributed to key individuals and agencies working in the area of suicide prevention in the province. Up-to-date, reliable information about the nature and circumstances surrounding completed suicides is essential to good prevention planning and programs.

Underwater Council of British Columbia

The Underwater Council of British Columbia states that "through education and communication, it is dedicated to furthering safe diving practices." As such, the Council undertakes to review all Coroners Service diving files on a yearly basis to produce a recreational diving fatalities report that summarizes circumstances and recommendations on diving deaths. This report is an invaluable reference for scuba instructors, educators and concerned scuba enthusiasts.

Canadian Agricultural Injury Surveillance Program

The purpose of the Canadian Agricultural Injury Surveillance Program is to collect and interpret information on agricultural injury across Canada. They review all cases identified by the Coroner as 'farm' related and abstract data from the files. The results are combined with data from other provinces to form the National Registry of Farm Fatalities. A final report is produced which aims to summarize risks, trends and other patterns among farm fatalities. This provides farm safety specialists with an objective basis from which to develop and target farm safety programs in B.C.

STATISTICS

CASELOAD STATISTICS (1999)

TOTAL CASES

Manner of Death	Total Cases
Natural	3265
Accident	1253
Homicide	103
Suicide	496
Undetermined	189
Non Coroners	3700
Total	**9006**

REGIONAL DISTRIBUTION

	Natural	Accident	Homicide	Suicide	Undetermined	NCC
Nanaimo	255	87	5	53	20	288
Victoria	394	135	10	57	19	543
New Westminster	660	186	26	89	31	715
Abbotsford	385	102	12	45	37	420
Vancouver	696	280	26	109	36	741
Kamloops	375	209	10	52	7	328
Kelowna	293	103	6	42	6	437
Prince George	207	151	8	49	33	228
Total	**3265**	**1253**	**103**	**496**	**189**	**3700**

REGIONAL CASELOAD REVIEW (1995-1999)

	1999	1998	1997	1996	1995
Nanaimo	708	799	758	881	851
Victoria	1158	1069	1097	1132	122
New Westminster	1707	1936	1933	2378	2009
Abbotsford	1001	1047	1081	776	726
Vancouver	1888	2053	1941	1962	1914
Kamloops	981	972	1062	1063	1051
Kelowna	887	1063	1082	1014	987
Prince George	676	695	626	694	693
Total	**9006**	**9634**	**9580**	**9900**	9353

* *The B.C. Coroners Service operates in a "live" database environment, and as such, data is continuously updated.*

ACCIDENTAL DEATHS (1999)

RECREATIONAL

Swimming	11
Sailboating/Sailboarding	-
Power Boating	10
Non Power Boating	-
Kayak	1
Innertube	1
Dinghy	-
Rowboat	3
Canoe	1
Rafting	1
Other	2
Scuba Diving	3
Snorkelling	1
Windsurfing	-
Diving	1
Hunting	1
Fishing	15
Snowskiing	6
Heli skiing	1
Snowmobiling	4
Snowboarding	3
Tobogganing	-
Skateboarding	-
Hiking/Climbing	11
ATV/Offroad Motorcycling	4
Skydiving/Parachuting	-
Ultra-light Aircraft	4
Team Sports	2
Mountain biking	2
Other	**37**

OCCUPATIONAL

Farm/Worksite	1
Mine, Quarry, Oil/Gas	2
Construction:	
- Residential	1
- Commercial	7
- Excavating/Paving/Grading	1
Electrical/powerlines	1
Industrial Sites	3
Material Handling	3
Forestry/Logging Sites	13
Railway Sites	2
Fishing/Hunting/Trapping	1
Commercial Scuba Diving	-
Movie Industry sets	1
Other	20

OTHER ACCIDENTS

Motor Vehicle	413
Alcohol/Drug Poisoning	346
Fall	173
Other	35
Drowning *(Does not contain drownings included in recreational category, i.e. swimming)*	18
Airway Obstruction	30
Fire	30
Air Crash	-
Exposure	11
Carbon Monoxide Poisoning	3
Explosion	-
Farm	3
Firearms	-
Railway	-
Non-Traffic (on driveway etc.)	1
Pedal Cyclist	-
Unclassified	9*

* *Unclassified represents cases in which the cause of death has not yet been finalized.*

Motor Vehicle Accidents

By Victim Type

Driver	201
Passenger	107
Motorcyclist	26
Pedestrian	66
MVA/Pedal Cyclist	11
MVA/Train Collision	1
Other	1
Unclassified	-
Total	**413**

Regional Distribution

	Driver	Passenger	MotorCyclist	Pedestrian	PedalCyclist	MVA/Rail	Other	Unclassified	Total
Fraser Valley	25	14	4	2	1	-	-	-	46
Kamloops	51	25	7	6	2	-	-	-	91
Kelowna	23	15	3	4	2	-	-	-	47
Nanaimo	12	6	2	3	1	-	-	-	24
New Westminster	26	13	6	17	3	1	-	-	66
Prince George	36	25	2	7	1	-	1	-	72
Vancouver	18	5	1	25	1	-	-	-	50
Victoria	10	4	1	2	0	-	-	-	17
Total	**201**	**107**	**26**	**66**	**11**	**1**	**1**	**-**	**413**

Child Death Review (Ages 0-18 yrs)

Total Cases Reported, 1995-1999

	1999	1998	1997	1996	1995
Natural	50	49	68	75	88
Accident	105	91	110	112	124
Homicide	9	4	19	14	5
Suicide	22	17	29	15	26
Undetermined	20	15	10	11	11
Non Coroners	46	45	50	50	58
Total	**252**	**221**	**286**	**277**	**322**

Age Distribution

	1999	1998	1997	1996	1995
<1 yr	76	68	89	99	125
1 - 4	29	28	31	28	22
5 - 9	16	21	31	26	21
10-14	35	27	34	34	39
15-18	96	77	101	90	115
Total	**252**	**221**	**286**	**277**	**322**

Accidental Child Deaths by Means of Death

	1999	1998	1997	1996	1995
Motor Vehicle	69	51	62	62	75
Drowning	13	11	10	16	11
Airway Obstruction	5	3	5	5	12
Falls	-	3	5	4	6
Alcohol/Drug Poisoning	3	4	4	7	2
Fire	1	5	2	2	2
Air	-	-	-	1	2
Other	13	9	21	15	14
Outstanding Cases	1	5	1	-	-
Total	**105**	**91**	**110**	**112**	**124**

** The B.C. Coroners Service operates in a "live" database environment, and as such, data is continuously updated.*

Sudden Infant Death Syndrome

Sudden Infant Death, 10-Year Review (1990-1999)

Year	No. of Deaths
1990	67
1991	78
1992	64
1993	50
1994	40
1995	50
1996	25
1997	26
1998	13
1999	13

Sudden Infant Death (Regional Distribution)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Fraser Valley	1	5	8	-	3	5	1	1	1	1
Kamloops	7	8	2	5	4	6	2	2	2	1
Kelowna	1	4	5	2	1	3	-	1	2	1
Nanaimo	10	7	11	9	8	8	5	4	1	2
New Westminster	15	23	11	12	13	9	8	7	2	2
Prince George	17	14	6	11	3	9	3	4	2	2
Vancouver	9	11	15	5	4	4	2	3	1	1
Victoria	7	6	6	6	4	6	4	4	2	3
Total	**67**	**78**	**64**	**50**	**40**	**50**	**25**	**26**	**13**	**13**

SUICIDES

B.C. SUICIDE RATES PER 100,000 POPULATION

Year	Number of Suicides	Rate per 100,000
1986	483	6.0
1987	59	15.0
1988	456	14.6
1989	489	15.3
1990	426	12.9
1991	488	14.4
1992	514	14.8
1993	492	13.8
1994	513	14.0
1995	534	14.2
1996	557	14.3
1997	583	14.7
1998	508	12.7
1999	496	12.3

B.C. FIVE-YEAR SUICIDE REVIEW

AGE:

	1999	1998	1997	1996	1995
< 13 yrs	-	1	3	1	0
13 - 19	23	22	37	18	35
20 - 29	67	74	95	91	109
30 - 39	108	107	129	129	124
40 - 49	112	130	128	125	86
50 - 59	88	77	80	71	67
60 - 69	39	42	49	57	50
70 - 79	36	31	39	36	41
Over 80	23	24	23	29	22
Total	**496**	**508**	**583**	**557**	**534**

SEX:

	1999	1998	1997	1996	1995
Males	393	393	459	429	425
Females	103	115	124	128	109

REGION:

	1999	1998	1997	1996	1995
Fraser Valley Region	45	45	49	53	26
Kamloops Region	52	58	67	59	63
Kelowna Region	42	40	50	44	49
Nanaimo Region	53	55	59	69	54
New Westminster	89	95	110	107	124
Prince George Region	49	41	52	39	41
Vancouver Region	109	113	133	129	117
Victoria Region	57	61	63	57	60

SUICIDES BY METHOD OF DEATH:

	1999	1998	1997	1996	1995
Hanging	166	153	178	165	148
Carbon Monoxide	53	72	54	76	65
Drowning	14	19	26	28	20
Falls	26	24	43	39	40
Firearms	115	102	134	110	138
Incised Injuries	9	11	16	11	9
Other	15	13	23	18	8
Poisoning	93	111	103	110	106
Unclassified	5	3	6	-	-
Total	**496**	**508**	**583**	**557**	**534**

ILLICIT DRUG OVERVIEW

In June 1993, the Minister of Health and the Attorney General of BC announced in the Legislature the appointment of the Chief Coroner to head up a task force to inquire into what appeared to be an inordinately high number of deaths associated with the illicit use of heroin. Deaths due to the use of illicit drugs became an epidemic in British Columbia, increasing from 39 deaths in 1988 to 361 in 1993 as highlighted by the following statistics:

B.C. ILLICIT DRUG DEATHS

Year	# of deaths
1988	39
1989	67
1990	82
1991	124
1992	164
1993	361
1994	317
1995	224
1996	312
1997	310
1998	413
1999	282

This table represents the number of Non Therapeutic (Illicit) drug deaths in B.C. where the CAUSE OF DEATH was due to or as a consequence of a DRUG OVERDOSE. This category includes cocaine, heroin, and illicitly purchased methadone. This table does NOT include cases where illicit drugs may have contributed to but were not the cause of death.

ILLICIT DRUG DEATHS BY AGE/SEX

AGE:

	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990
<=20 yrs	12	10	6	16	6	8	9	3	3	0
21 - 30	50	72	61	77	57	71	63	40	33	29
31 - 40	111	171	141	130	96	165	192	80	58	42
41 - 50	84	123	81	74	52	60	79	31	20	9
51 - 60	24	35	17	11	11	10	13	8	8	2
Over 60 yrs	1	2	4	4	2	2	5	2	2	0
Total	**282**	**413**	**310**	**312**	**224**	**317***	**361**	**164**	**124**	**82**

SEX:

	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990
Male	231	341	266	255	192	267	295	136	97	66
Female	51	72	44	57	32	50	66	28	27	16

** One case for 1994 for which age undetermined.*

Inquest Statistics (1999)

Classification of Death

Natural	9
Accident	11
Suicide	6
Homicide	3
Undetermined	1

Type of Death

Police Custody/Lockup	
Federal Correctional Facility	18
Police Cell Lock-up	3
Police Custody	2
Police Shooting	1
Police - Other	2
Industrial	1
Other	2
TOTAL	**29**

Summary of Inquest Recommendations & Responses

In 1998, the Coroners Service held 29 inquests. The following summaries are brief indicators of the subject matter of the inquests, the juries' recommendations and the responses received at the time of writing. The case histories are not based on transcript information and, therefore, do not definitively represent evidence as presented at these inquests.

Inquest No. 1

(Correctional Facility)

On January 4, 1999, an inquest was held at Burnaby, B.C. into the death of a 42-year-old female who died on May 15th, 1998, of a drug overdose.

The subject was admitted to the British Columbia Correctional Centre for Women on May 14, 1998. The following day she was discovered non-breathing during a routine cell check. Despite medical attention, she died at the facility.

The jury found that the death resulted from an acute multi-drug ingestion (Diphenhydramine & cocaine) and classified the death as an accident.

The recommendations of the jury, which were forwarded to the BC Correctional Centre for Women, were as follows:

1. That the BC Correctional medical staff respond to emergencies in a "trauma" manner, taking a crash medical kit and oxygen, without the determination of the nature of the medical emergency.
2. That a medical emergency procedure be established.
3. That all correctional staff, control staff, and medical staff have a definite protocol for attaining, reviewing and upgrading First Aid and Cardio-pulmonary resuscitation procedures.
4. That an in-house review of communications equipment effectiveness may be warranted.

Responses:

Burnaby Correctional Centre for Women (BCCW)

1. It continues to be the expectation that medical staff respond to all medical emergencies in a "trauma" manner. The kits are maintained with equipment that enables the medical staff to respond to all types of medical emergencies as outlined in the protocols.
2. Emergency codes are being reviewed on a province-wide basis. BCCW will amend their practice to bring it into line with provincial standards, once they are established.
3. There is a protocol in place to ensure that all correctional staff are current in First Aid training, which includes CPR. Re-certification of a number of staff has just been completed.
4. The problems with the communication equipment appears not to be a wide spread problem. Should consistent problems be identified, testing will be conducted to determine the nature of the problem.

Inquest No. 2

(Police Custody)

On January 21, 1999, an inquest was held at Abbotsford, B.C. into the death of a 33-year-old male who died on August 13th, 1998, at M.S.A. General Hospital.

Police responded to a call by the parents of the subject to attend to their residence as the subject was displaying sudden violent and aggressive behaviour towards them. It was observed that

the subject swallowed an unknown quantity of pills prior to the police arrival. His condition was stabilized sufficiently to have the ambulance transport him to M.S.A. General Hospital. Enroute the police were again summoned to assist the ambulance crew to subdue his violent behaviour within the BC Ambulance Service vehicle. One of the police members then rode with the ambulance until it arrived at the hospital. The subject's violent and uncooperative behaviour continued for a short time at the hospital, until he lost consciousness.

The jury found that the death resulted from a drug overdose as a result of ingestion of cocaine and propafenone and classified the death as an accident.

There were no recommendations.

INQUEST NO. 3

(POLICE CUSTODY)

On January 27, 1999, an inquest was held at Kamloops, B.C. into the death of a 22-year-old male who died on January 7, 1998, at Kamloops Regional Correctional Centre.

The subject was arrested by the Kamloops City RCMP Detachment with respect to several sexually related offences. Minutes before his arrest, he slashed both his wrists in an apparent suicide attempt. The subject received treatment for the wounds at Royal Inland Hospital and was later remanded to the Kamloops Regional Correctional Centre. The subject was assessed as a suicide risk and placed in a segregation unit observation cell. The subject had difficulty coping with the isolation, was later assessed to be no longer an acute suicide risk and was transferred to the general remand unit. The subject was then found hanging in his cell during a routine inmate count and security inspection.

The jury found that death resulted from asphyxia as a result of hanging and classified the death as a suicide.

The recommendations of the jury, which were forwarded to the Kamloops Regional Correctional Centre and the Corrections Branch, were as follows:

Kamloops Regional Correctional Center

1. That if the current meal break schedule is continued, i.e. all correctional officers eating at the same time, that the prowl officers be dedicated to checking duty during that time and have no other duties assigned for that period.
2. That where an inmate has a long history of dangerous behaviour, to himself or others, this information be more effectively communicated to the correctional officers dealing with the inmate.

Corrections Branch

1. That there be a review and increase of available time allotted to Adult Forensic Psychiatric Services social workers and psychiatrists to provide psychiatric services to inmates in the care and custody of the Corrections Branch.

RESPONSES:

Kamloops Regional Correctional Centre (KRCC)

1. KRCC has adjusted overcrowding staffing shifts to provide more staff during the meal period. A security risk inmate list has been implemented. This identifies inmates who are a security risk, suicide risk and those on 15 minute checks. This list is distributed to all operations staff. The local union has been engaged to get an agreement to change the hours of work for the control/prowl position. The OIC has been directed to ensure that there is sufficient staff coverage for lunch hours.

2. The second recommendation is difficult to implement as the information is often not known or , if known, not available for general release. The KRCC has several methods for identifying dangerous or self-harm, including Visen, the RCMP, family/friends, screening on intake and the nurse's examination. Since this incident, a security risk inmate list has been distributed to all operations staff. If the self-harm history is not brought forward to Corrections or police agencies, then the history is considered confidential personal medical history and there is no legal mechanism to access the information.

INQUEST NO. 4

(OTHER)

On February 1, 1999, an inquest was held at Burnaby, B.C. into the death of a 23-month-old female who died on February 28th, 1996, in Vancouver, B.C.

This inquest involved the death of a 23-month-old female who died as a result of multiple blunt force injuries.

The jury found that death resulted from blunt head trauma and classified the death as a homicide.

The recommendations of the jury, which were forwarded to the Attorney General, Assistant Deputy Attorney General, the Minister of Health, and the Ministry for Children and Families, were as follows:

Attorney General

1. That training in child abuse recognition, to include child interviewing techniques, be made mandatory with all police agencies in B.C.

Deputy Attorney General, Criminal Justice

1. That this complete file be reviewed and necessary actions be taken.
2. That a transcript of these proceedings be forwarded to the Langley RCMP Detachment for further review.

The Minister of Health

1. That mandatory written communication of all visits by a child to any health care agency be forwarded to the family physician.
2. That a system of tracking/flagging of children seen by British Columbia medical personnel, who suspect child abuse, be initiated.
3. That all British Columbia health care professionals be trained in the recognition of child abuse and that policies and procedures be clearly written as to the action plans they undertake.
4. That a mandatory written handout be given to caregivers explaining the symptoms of post-traumatic head injuries.
5. That medivac operations be expanded to include alternate air transportation when primary emergency air vehicles are out of service or in operation already.

Ministry for Children and Families

1. That all child protection social workers with the Ministry for Children and Families be formally trained in the recognition of child abuse and that policy and procedures be clearly written as to action plans they undertake.
2. Increase the number of child protection social workers with the Ministry for Children and Families, thereby reducing the social worker to case ratio.
3. Persons identified as the caregiver by the Ministry attend family management courses (i.e. anger management) and that follow up checks be made by the Ministry to verify completion. That immediate funding be

provided for increasing the number of beds in the Eric Martin Pavilion and other psychiatric facilities throughout the Province.

RESPONSES:

Attorney General

1. Jury recommendation #1 has been passed on to the Inter-Ministry Child Abuse Committee for their information and consideration. The Committee is in the final stages of developing an inter-ministry (including the RCMP and municipal police agencies) child abuse policy format and operational guide. Advanced Child Sexual Assault training now available for police and Crown will also be expanded to include child abuse cases which primarily involve the identification and investigation of abuse and neglect.

Minister of Health

1. The recommendations appear to be broad in scope. They will be directed to relevant staff in the Ministry to consider, follow up and make appropriate consultations as necessary. Once this information is received and action plans determined, further details will be provided.

Ministry for Children and Families

1. The Ministry has implemented a number of initiatives to address these recommendations, including a fifteen-week training program for all new social workers. Other initiatives include: risk assessment training, a risk assessment tool, child protection standards, child protection investigation training, and publication of the new B.C. Handbook for Action on Child Abuse and Neglect.
2. There has been an increase in the number of social workers to address the workload issues. In 1996/97 there was an allocation of 240 FTEs for new social worker positions. In 1998/99 there was an additional allocation of 250 FTEs, 225 of which were social worker positions primarily in the protection field.
3. The Ministry currently is using a comprehensive risk assessment model and the development of a harm reduction plan addresses planning with the caregivers. The Ministry has also developed an Integrated Case Management model for the practice of child welfare.

INQUEST NO. 5

(CORRECTIONAL FACILITY)

On February 25, 1999, an inquest was held at Chilliwack, B.C. into the death of a 33-year-old male who died on January 26th, 1998, at Chilliwack General Hospital.

The subject was serving a federal sentence at Mountain Institution. He was described as a fit, muscular individual. While engaging in a floor hockey game in the gymnasium, the subject was witnessed to collapse onto the floor. He was quickly attended to by the other inmates and a phone call was placed to the Health Care Unit. The subject was pronounced dead on arrival at Chilliwack General Hospital.

The jury found that the cause of death was cardiac arrhythimia due to ischemic heart disease and classified the death as natural.

The recommendations of the jury, which were forwarded to Correctional Service of Canada, were as follows:

1. That empty oxygen tanks be kept separate from the full ones.
2. That a better code system for making health care workers aware of serious situations (instead of using 'man down').
3. That there be a central number for emergency use only and all staff be made aware of the number.

4. That CPR training be mandatory for Corrections Officers and encouraged for inmates.

RESPONSES:

Correctional Service of Canada

1. Recommendation #1 was accepted and the Chief of Health Services advises that the full oxygen tanks have been moved to the hallway of the Health Service Clinic.
2. A memo was distributed to staff by the Chief Health Nurse to clarify the 'man down' expression. Staff has been told to be more precise when requesting medical assistance.
3. The Institutional Telephone List has identified under Chief of Health Services the Emergency Calls telephone number as 479. Staff have been instructed to use this telephone number when contacting Health Services for emergency procedures.
4. In 1994, The Executive Committee of the Correctional Service of Canada (CSC) approved the National Training Standard on First Aid and CPR. It is essential that all designated staff be qualified and provided with annual re-certification on CPR. First Aid and CPR is also a prerequisite for all Correctional Officers who are invited to the Correctional Training Program, prior to being hired by CSC.

INQUEST NO. 6

(INDUSTRIAL)

On March 1, 1999, an inquest was held at Duncan, B.C. into the death of a 50-year-old male who died on October 21st, 1997, at the Fletcher Challenge Canada Ltd. Pulp & Paper Mull in Crofton, B.C.

The subject was one of two management employees performing maintenance duties while the paper mill was shut down due to a protracted labour dispute. One of the subjects was found at the opening of a large enclosed de-aerator vessel, while the other was found on the floor of the interior of the vessel. It was found that nitrogen gas had been leaking out of a power boiler into a steam line, then into a drain line which fed into the de-aerator system. This created an oxygen deficiency inside the vessel. Testimony indicated that the subject entering the vessel would have collapsed and lost consciousness within seconds of entering the confined space.

The jury found that death resulted from hypoxic hypoxia due to lack of oxygen and classified the death as an accident.

The recommendations of the jury, which were forwarded to Fletcher Challenge Pulp Operations Ltd., the Workers' Compensation Board, the Canadian Standards Association, Pulp, Paper and Woodworkers of Canada, and the Boiler, Gas and Railway Safety Branch, were as follows:

Fletcher Challenge Pulp Operations Ltd., the WCB, the Canadian Standards Assocation and the Pulp and Paper Woodworkers of Canada:

1. That Fletcher Challenge Canada Ltd. undertake a written workplace hazard analysis concerning the application of nitrogen and other inert gas pads to preserve boilers.
2. That Fletcher Challenge Canada Ltd. develop a written procedure for applying a nitrogen pad to the boilers.
3. That the workplace hazard analysis and written procedure include provision for determining the points at which nitrogen may leak from the pad and for addressing any workplace hazard thereby created.
4. That Fletcher Challenge Canada Ltd. review all lockout procedures for work on the boilers, piping and auxiliary vessels to ensure they take into account the circumstances of a nitrogen pad being in place at the time of lockout.

5. That a review of the confined space training for all workers be done with a view to seeing their training refreshed annually and retraining take place every two years.
6. That Fletcher Challenge Canada Ltd revise their safety program to include written procedures for a safety committee of non-union members to function during labour disputes.
7. That the above written procedures make provision for test, vent, test procedures whether the Worker's Compensation Board amends its regulations or not.
8. That Fletcher Challenge Canada Ltd. instruct every employee that a confined space shall never be entered without following company and Workers' Compensation Board procedures and that Fletcher Challenge Canada Ltd. keep a written, signed record of that instruction.
9. That the WCB amend its regulations to make it clear that before opening confined space or immediately upon opening a confined space a test be done using existing inspection valves or ports to establish a baseline of what is present in that confined space, then to ventilate and test again before worker entry in all cases where there is a reason to doubt the contents of the confined space.
10. That every confined space have a sticker or sign placed next to the entrances which states that to enter without conforming to plant and Workers' Compensation Board procedures constitutes an offence.
11. That the workplace hazardous material information system be reviewed to ensure it is up-to-date and be made it available to all employees.
12. That the WCB improve their hazard alert distribution procedure and add hazards alert to their Internet Web page.
13. That revision and publication of the Workers' Compensation Board Confined Space Standard Practice Manual be fast tracked.
14. That the WCB improve their notification to employers and workers when significant changes or revisions are made to a WCB Standard Practice Manual.
15. That the WCB consider incorporating reference to Standard Practice Manuals within the regulations.
16. That WCB develop a standard lesson plan on confined space entry, including hazard recognition, for use by industry in their training programs.
17. That the WCB review and recognize confined space training courses which meet a basic standard or criteria for the training of workers.
18. That the Canadian Standards Association pursue the development of a Confined Space Entry Standard similar to its Respiratory Protection Standard.
19. That the WCB Occupational Health & Safety Officers have authority to enter work sites during labour disruptions.
20. The WCB, Fletcher Challenge Canada Ltd. and the Unions put aside their differences and commit themselves to sharing knowledge, experience and skills to promote a good working relationship.
21. That Fletcher Challenge Ltd. develop a system to account for employees' safety on site, e.g. swipe card system.
22. That all workers in confined spaces wear a continuous gas monitoring system.
23. That any modification or alteration to existing boilers, piping or pressure vessels be immediately labeled to identify hazards and/or content.
24. That Fletcher Challenge Canada Ltd. ensure person(s) trained in accident investigation are available on each shift.
25. That all gas monitoring equipment be kept at the Fletcher Challenge Canada Ltd. Safety Office and signed in and out by qualified personnel.

26. That Fletcher Challenge ensure training records are accessible to those authorized on a 24 hour basis.

27. That best efforts be exercised to ensure the wide dissemination of these Jury recommendations within Fletcher Challenge Canada Ltd.'s own workforce and the pulp and paper industry in British Columbia generally.

Boiler, Gas and Railway Safety Branch

1. That the Ministry of Municipal Affairs, Boiler, Gas and Railway Safety Branch advise all industries in B.C. of the dangers of nitrogen.

2. That all new pressure vessels that can be entered be equipped with an inspection port for testing of hazardous atmosphere.

RESPONSES:

Fletcher Challenge Canada Ltd.

1. A written hazard analysis for nitrogen has been completed and posted on the company intranet.

2. A procedure for applying nitrogen pads to boilers has been completed and a copy posted on the company Intranet.

3. The hazard analysis includes nitrogen leakage points.

4. A review of the lockouts for boilers, piping and vessels to account for nitrogen pads was included in the hazard analysis.

5. A confined space refresher training was completed in 1998. This was prompted by WCB regulation revisions. These refresher training sessions will be held annually.

6. A policy letter has been developed and filed with the safety coordinator and human resources relating to written procedures on non-union safety committees during strikes. The policy will be implemented during pre-strike preparations.

7. Provisions for test, vent, test before entering confined spaces has been included in the new confined space entry procedure.

8. The training sessions instruct every employee that confined space should not be entered without following WCB procedures, with written, signed record of instruction.

9. All confined spaces that are open have either an attendant present or signage indicating confined space.

10. The workplace hazardous material information system tank and pipe labeling is underway. This information is accessible through Fletcher's Website.

11. Swipe card initiatives have been agreed to by the union. This issue to be raised for approval and installation in early fiscal 2000. Fencing is part of this effort. This initiative will be done over a three year period due to cost.

12. The use of gas monitors is as specified in the confined space entry procedure.

13. The identification of any modifications or alterations to existing boilers, piping or vessels has been addressed during hazard assessments.

14. Supervisors are trained in accident investigations and are available on each shift.

15. A formal program is in place for all gas monitoring equipment to be kept at the safety office and signed out by trained personnel.

16. A 24-hour access to training records is in place on Haggerty computer system.

17. The jury recommendations have been widely disseminated.

18. All pressure vessels are built to ASME code. It is not practical to retrofit existing vessels.

The Workers' Compensation Board (WCB)

1. With regard to recommendation #9, The WCB promulgated the new Occupational

Health and Safety Regulation effective April 15, 1998. Part 9 of the new OH & S regulation is devoted to confined spaces and confined space entry.

2. Identification of confined spaces is mandated by Sections 9.3 and 9.12 of the new Occupational Health and Safety Regulations. It is an offence to violate any part of the regulation.
3. The WCB has been developing hazard alerts for over 30 years. The entirety of these alerts will be put onto the Board's Internet Web page and onto CD-Rom. It is expected that this project will be completed by the end of 1999.
4. The revision of and publication of the WCB's Confined Space Standard Practice Manual has been fast-tracked. It is anticipated that it will be completed in early 2000.
5. Currently, employers and workers are notified of new publications and changes to existing publications through the Board's publication Prevention at Work. The technical writing group will now alert the Board's public affairs department to any change to a WCB publication. Public affairs will decide if the change warrants advice to the media. In addition, a means of alerting employers and workers via the WCB Internet Web site is being investigated.
6. Standard Practice Manuals are referenced in the new Occupational Health and Safety Regulations. The Board's revision to the Confined Space Entry Manual had not been completed by the time that the stakeholders met to develop the new Occupational Health and Safety Regulation. Accordingly, it could not be incorporated by reference.
7. The Prevention Division has developed a standard lesson plan for training field officers in respect to confined space entry. This lesson plan is available to industry for their use.
8. With regards to the recommendation that WCB review and recognize confined space training courses, it would be possible to develop a course with sufficient content that would allow an educational partner to certify students. The course offered by an educational partner would need a suitable accommodation of course work and practical experience to allow the student to be certified as proficient. It is the view of the prevention division that sometimes certification may have a detrimental affect. Employers may tend to view certified persons as persons who do not need to adhere to establish procedures or submit to appropriate supervision. This recommendation, however, will be referred to the policy bureau for consideration in ongoing review of the Occupational Health and Safety Regulation.
9. A provision of the Occupational Health and Safety Policy offers guidance to officers with respect to how to address entry during labour disputes. This policy does not remove the right of officers to enter, but does require consultation with the union involved and the officer's manager. This policy, however, is under review as part of the complete revision of the prevention divisions' Policy Manual.
10. Cooperation with the employers is a mainstay of the prevention division's strategy. Intervention is not designed to be confrontational. The prevention division of the WCB is however, imbued with regulatory authority under the provisions of the Workers' Compensation Act. Inevitably, the assertion of lawful authority may sometimes create confrontation. The board will continue to emphasize that it offers services to employers and workers in terms of education, consultation and enforcement as required.

The Pulp, Paper and Woodworkers of Canada

1. The jury's recommendations should alleviate any reoccurrence of this tragic event. The

union has put aside their differences with Fletcher Canada in regards to safety, and is very actively seeking to make Crofton Pulp and Paper a safe place to work.

The Canadian Standards Association and the Boiler, Gas and Railway Safety Branch have not yet responded.

INQUEST NO. 7

(CORRECTIONAL FACILITY)

On March 24, 1999, an inquest was held at Kamloops, B.C. into the death of a 33-year-old male who died on October 12th, 1998, at Kamloops Regional Correctional Centre.

The subject was an inmate at the Kamloops Regional Correctional Centre (KRCC) and was serving a sentence for bank robbery. He was found in his bed in cardio-respiratory distress.

The jury found that death resulted from an acute cardio-respiratory failure due to a morphine overdose and classified the death as an accident.

The recommendations of the jury, which were forwarded to the Kamloops Regional Correctional Centre , were as follows:

1. That KRCC consider the installation of a camera in the visiting area.
2. That KRCC review security measures regarding anyone having access to the institution in order to restrict the availability of illicit drugs.
3. That KRCC consider instituting a written procedure regarding resuscitation and ensure that staff are adequately trained to implement this procedure.

RESPONSES:

1. Since this death, the KRCC has instituted a wide range of drug interdiction measures. This includes reconstruction of the visits office to provide 100% visibility and immediate/direct staff access to the visits area, construction and operationalization of the divided 'long table' to ensure physical separation of inmates and their visitors, periodic and random use of the Corrections 'drug dog' program, etc. In addition, KRCC has formally requested the purchase of an ion scanner for drug detection and a camera system for the visiting area. Both of these items are subject to available resources.
2. Provision of safe custody for the inmate population is an integral part of the security/correctional officers role. Maintenance of safety and security of inmates/residents is part of the generic job description which is taught to all prospective employees in the basic Justice Institute training program. All line corrections staff are required to hold at least a level 1 WCB certification and the employer encourages its maintenance through (1) full tuition subsidy (2) paid training time and (3) provision of biannual on-site courses.

INQUEST NO. 8

(POLICE CELL)

On April 7, 1999, an inquest was held at Burnaby, B.C. into the death of a 32-year-old male who died on June 24th, 1998, at Vancouver, B.C.

The subject was a known abuser of heroin and cocaine. He was arrested on June 23rd on the basis of being found in possession of both heroin and cocaine for the purposes of trafficking. The arrest was non-violent and the subject walked the approx. 3 blocks to the Vancouver Police Building. He was taken to the cell area and booked. The subject requested a transfer to hospital and indicated to the booking guard that he had ongoing medical problems. A nurse was called to assess the subect. He did not appear to be in any distress and was not sent to hospital. On June 24th, the subject was found unresponsive in is cell.

The jury found that the cause of death was acute cocaine overdose and classified the death as accidental.

The recommendations of the jury, which were forwarded to the Vancouver City Police, were as follows:

1. That all jail nurses attend "Nursing Assessing Skills" at BCIT to be paid by the Vancouver Police Department.
2. That a yearly CPR re-certification course be mandatory.
3. That VPD review existing protocol and update as necessary every 3-4 years.
4. At nurse shift change, ensure that incoming nurse reads and signs off on nurses log.

RESPONSES:

Vancouver City Police Department

1. The Department closed its Jail in August, 1999. The Jail is now a Provincial facility. The four recommendations no longer apply to the Department because of the transfer of responsibility.

INQUEST NO. 9

(CORRECTIONAL FACILITY)

On April 14, 1999, an inquest was held at Victoria, B.C. into the death of a 45-year-old male who died on November 16, 1998, at Victoria, B.C.

The subject was an inmate of William Head Institution. He was serving a life sentence for second degree murder. Evidence at inquest indicated that the subject reported to the health care unit of William Head Institution and informed the nurse that he was having back and pelvic pain. Medication was ordered. However, the subject was transferred to Victoria General Hospital as it was clear he required medical attention. He died shortly thereafter.

The jury found that death resulted from exsanguination due to rupture of post-traumatic aneurysm and classified the death as natural.

The jury made no recommendations.

INQUEST NO. 10

(CORRECTIONAL FACILITY)

On April 28, 1999, an inquest was held at Victoria, B.C. into the death of a 33-year-old male who died on January 9th, 1999, at Victoria, B.C.

The subject was an inmate at Vancouver Island Regional Correctional Centre (VIRCC). He was admitted as a result of charges laid for breaking and entering and robbery. The subject was known to have a long-standing history of drug abuse. On routine rounds, the subject was found unresponsive in his cell.

The jury found that death resulted from acute respiratory failure due to a heroin overdose and classified the death as an accident.

The issue of drug interdiction strategies in custodial settings was raised at inquest. In 1997, the Ministry of Attorney General, Corrections Branch initiated a project to review how to reduce the amount of illict narcotics entering the B.C. Corrections Branch adult custodial facilities. The recommendations of the review were implemented as a matter of policy. The Director of Operations at VIRCC testified that many security improvements have been made in the last few years to reduce the opportunity for drugs to enter the institution.

The jury made no additional recommendations.

INQUEST NO. 11

(CORRECTIONAL FACILITY)

On April 30th, 1999, an inquest was held at Abbotsford, B.C. into the death of a 68-year-old male who died December 4, 1998, at Abbotsford, B.C.

The subject was serving a federal sentence at Matsqui Regional Psychiatric Centre. He complained of difficulty breathing and chest pains while in his cell. The subject expired enroute to hospital.

The jury found that death resulted from a myocardial infarction and classified the death as natural.

The jury made no recommendations.

INQUEST NO. 12

(POLICE - OTHER)

On May 3, 1999, an inquest was held at Kitimat, B.C. into the death of a 44-year-old male, who died on November 27, 1998 at Kitmat, B.C.

On November 27, 1998 three members of the Kitmat RCMP arrived at the subject's residence to execute a search warrant. This warrant was issued pursuant to the Criminal Code of Canada sections dealing with possession of child pornography and sexual interference with a person under the age of fourteen years. The subject refused to answer the door for the police. While police attempted to unlock the door, the subject fired two bullets through the door. A constable was struck in the lower leg. Subsequently, the area was secured. Residents from attached and surrounding townhouses were evacuated. The police contacted the subject by telephone but were unsuccessful in persuading the subject to surrender.

The RCMP Emergency Response Team (ERT) attended, but ERT negotiator was also unsuccessful in persuading the subject to leave the residence. Shortly thereafter, the ERT members heard a single gunshot from within the premise. Under the cover of tear gas, members of the ERT made a forced entry into the residence and found the subject deceased from an apparent self-inflicted gunshot wound.

The jury found that death resulted from a gunshot wound to the head and classified the death as a suicide.

The jury made no recommendations.

INQUEST NO. 13

(POLICE CELL)

On May 11, 1999, an inquest was held at Burnaby, B.C. into the death of a 56-year-old male who died on December 17, 1998, at White Rock, B.C.

The White Rock RCMP responded to a 911 call reporting an intoxicated male attempting to get into a parked vehicle. Police attended the scene and arrested the subject for being intoxicated in a public place. He was transported to White Rock RCMP detachment and lodged in a cell. Shortly after arrival, the subject was discovered unresponsive in his cell. Despite resuscitation efforts, the subject could not be revived.

The jury found that death resulted from acute alcohol ingestion and classified the death as an accident.

The recommendations of the jury, which were forwarded to the RCMP "E" Division and the Ministry for Children and Families, were was follows:

RCMP "E" Division

1. That consideration be given to creating a policy regarding intoxicated prisoners that, before they are left in a cell in anything but an awake state, that painful stimuli be administered to determine if they can be roused. If they cannot be roused, that medical attention be sought.
2. That circumstances of the death and findings of this inquest be shared with other RCMP detachments.

Ministry for Children and Families

1. That consideration be given to implementing detox centers, where practical, that would accommodate individuals such as the deceased.

RESPONSES:

RCMP, "E" Division

1. The RCMP is currently reviewing its policy dealing with the incarceration of persons who may be ill, injured, unconscious or of questionable consciousness. In the case of this subject, alcohol continued to be absorbed into his blood after he was arrested and placed in cells. The possibility of creating a policy on the use of painful stimuli on intoxicated persons prior to placing them in cells has been examined and considered as recommended; however, such an approach would not always identify all subjects requiring medical treatment and nor significantly reduce the occurrences of cell deaths. The use of stimuli is taught to members during first aid training. A copy of the jury's recommendation is being forwarded to the Officer in Charge, "E" Division Training Branch.
2. A bulletin is being forwarded to all detachments advising them of the details of this incident as well as the jury's recommendations emphasizing the need to be thorough when assessing the condition of intoxicated individuals prior to placing them in cells.

The Ministry of Children and Families, Addiction Services Branch

1. It would appear that the subject required medical care at a hospital as the subject was dealing with acute alcohol ingestion. Addiction Services provide detoxification for non-acute individuals and would have sent the subject to hospital. Where practical, the Province is providing detoxification services and continues to be vigilant about detoxification needs of individuals across British Columbia.

INQUEST NO. 14

(CORRECTIONAL FACILITY)

On May 17, 1999, an inquest was held at Victoria, B.C. into the death of a 35-year-old male who died on January 14, 1999, at Victoria, B.C.

The subject was an inmate at William Head Institution. After a confrontation with a Correctional Service of Canada officer, the subject became highly agitated and verbally abusive. He was admitted to the Segregated Cells Unit where he was later discovered on the floor under the bunk of his cell.

The jury found that death resulted from an acute drug overdose (amitriptyline) and classified the death as a suicide.

The recommendations of the jury, which were forwarded to the Correctional Service of Canada, were as follows:

1. That, with regard to the Segregated Cells Unit (SCU):
   a) ideally, a regular search of the SCU. cell units should ideally occur every eight hours;
   b) the Deister check should be mandatory, at some point within each hour, twenty-four hours a day, and a more regular

check of the Deister printouts should be made;

c) an auditory response from each cell unit, as/or if required, could be helpful to the "bubble officer";

d) procedures should be established and communicated for flagging a file;

e) all officers who work on S.C.U. the majority of their shifts, should have basic training in suicide awareness;

f) a camera be installed to monitor the exterior windows on the indoor exercise room;

g) the area around the wire mesh of the outside exercise area be regularly maintained to ensure ground-level vegetation for a three-metre wide strip.

2. That all SCU. officers should "log on" and "log off" for their shifts (4,7,8, or...hours) twenty-four hours a day.

3. That when a serious incident occurs in a SCU camera cell unit, after emergency procedures have been initiated, an officer will turn on the camera/video as part of the 'lockdown' procedures.

4. That all officers involved in an incident must remain available for questioning or de-briefing (unless there are exceptional, extenuating circumstances).

5. That, as with most jurisdictions across Canada, given the economic efficiencies the Correctional Service of Canada (CSC) is challenged by, CSC should strive to

a) within safety guidelines, re-think the task of modifying the side door jamb, and the base of the door for each cell unit, to lessen the chances of contraband entering or leaving a cell unit;

b) have a drug dog and handler visit on a more regular, but unpredictable, basis;

c) CSC staff not working on the SCU on a regular basis should not work the "bubble" solo;

d) CSC staff newly assigned to the SCU. would have an initiation period (after the additional training) totaling at least two weeks, and up to four weeks, where they are working with a SCU experienced CSC staff member on any shift;

e) give consideration to installing cameras in all of the cell units of the SCU (given its more 'maximum security' approach;)

f) personnel responsible for contributing to (or completing) a report on a prisoner returning to an institution from a unescorted temporary absence be encouraged to do so at the earliest possible date.

RESPONSES:

No response has been received to date.

INQUEST NO. 15

(POLICE-OTHER)

On May 26, 1999, an inquest was held at Penticton, B.C. into the death of a 54-year-old male who died on November 15, 1998, at Princeton, B.C.

The subject, a resident of Surrey, B.C, was stopped near Princeton, B.C. for erratic driving. The subject admitted to having consumed "a couple of drinks" and was issued a 24-hour driver's license suspension. The officer returned to his marked patrol car to complete the necessary paperwork. Upon exiting the patrol car, the officer heard a gunshot. The subject had shot himself. Investigation revealed that the subject had a history of periodic alcohol abuse and had seen his personal physician regarding depression.

The jury found that death resulted from a gunshot wound to the head and classified the death as a suicide.

The jury made no recommendations.

INQUEST NO. 16

(CORRECTIONAL FACILITY)

On June 3rd, 1999, an inquest was held at Chilliwack, B.C. into the death of a 44-year-old male who died on August 27, 1998, at Agassiz, B.C.

The subject was serving a federal sentence at Elbow Lake Institution. He had a long history of drug abuse while incarcerated. The subject was found deceased in his cell on a routine inmate count check.

The Deputy Warden of Elbow Lake Institution testified at Inquest that an administrative inquiry done of this incident resulted in the implementation of the following recommendations:

1) that Elbow Lake Institution complete the re-certification of staff on basic First Aid
2) that Elbow Lake Institution review the case management of the offender

The jury found that death resulted from heart failure due to a narcotic overdose and classified the death as undetermined.

The jury made no recommendations.

INQUEST NO. 17

(CORRECTIONAL FACILITY)

On June 15, 1999, an inquest was held at Mission, B.C. into the death of a 50-year-old male who died on February 22, 1999, at Mission Memorial Hospital.

The subject was serving a federal sentence at Mission Institution. Due to deteriorating health, he was transferred to Mission Memorial Hospital. He died at hospital.

The jury found that death resulted from multi-system failure due to pneumonia and classified the death as natural.

The jury made no recommendations.

INQUEST NO. 18

(CORRECTIONAL FACILITY)

On June 15, 1999, an inquest was held at Abbotsford, B.C. into the death of a 46-year-old male who died on January 5th, 1999, at Matsqui Institution.

The subject was serving a federal sentence at Mission Institution. The subject was transferred to Matsqui Institution Health Care Unit where he received cancer therapy. His condition deteriorated and he was found deceased in his bed.

The jury found that death resulted from metastatic cancer of the liver and classified the death as natural.

The jury made no recommendations.

INQUEST NO. 19

(CORRECTIONAL FACILITY)

On June 17, 1999, an inquest was held at Chilliwack, B.C. into the death of a 28-year-old male who died on July 10, 1997, at Agassiz, B.C.

The subject was serving a federal sentence at Kent Institution. On the afternoon of June 10, 1997, the subject was in the exercise yard with several other inmates for exercise. A correctional officer noted that the inmates appeared to be arming themselves with baseball bats and shortly after, an altercation broke out. A general broadcast for assistance brought all available staff to the exercise yard. Within minutes, the inmates were disarmed. During the course of the fighting, the subject suffered multiple stab wounds. The subject was pronounced dead at Chilliwack General Hospital.

The jury found that the cause of death was a stab wound to the chest and classified the death as a homicide.

The recommendations of the jury, which were forwarded to Correctional Services of Canada (CSC), were as follows:

1. That CSC investigate the possibility of better quality camera and or/more cameras, or better positioning of same.
2. That a walk through metal detector be considered at the entrance to the gym.
3. That more efficient or quicker servicing of the ion scanner or the use of a loaner when it is out of the service.

RESPONSES:

Correctional Service of Canada (CSC

1. Representatives from the Technical Services Branch, National Headquarters attended Kent Institution in September 1999 as part of a full security review of that facility. It was determined that the video multiplexer installed five years was no longer suitable for its initial purpose. It has been recommended to the Institution that a suitable multiplexer be used and also to reduce the number of cameras per videocassette recorder ratio. The existing camera locations meet the CSC Technical Services specifications.
2. The CSC National Security Review Team expressed serious concerns regarding the installation of a walk through scanner in this area. Their concern was that staff tends to become overly dependent upon static security devices, which leads to a false sense of security. It was also noted that walk through scanners will not detect lexan, stainless steel or brass. The team suggested that staff use hand held scanners in a dynamic process of non-intrusive searches and pat-downs. This suggestion was accepted and the Post Order on movement control was amended to "ensure that inmates are randomly frisked or hand scanned as they pass through the area."
3. The third recommendation has been resolved. The maintenance of the ion scanner is now handled through National Headquarters and a Canadian contractor, as opposed to an American contractor, and loaner units are available when the need arises.

INQUEST NO. 20

(POLICE CELL)

On June 2, 1999, an inquest was held at Burnaby, B.C. into the death of a 47-year-old male who died on February 17, 1999, at New Westminster, B.C.

The subject was arrested by Burnaby RCMP on February 13, 1999, for being drunk in a public place. Due to the lack of detoxification facilities in Burnaby, the subject was taken to the Burnaby RCMP Detachment and placed in a holding cell. His criminal record identified him as suicidal, violent and an escape risk. This information was communicated to the prison guard. No suicidal ideation was expressed by the subject to Burnaby RCMP while in custody. The subject was placed in a cell and was discovered hanging from his socks tied to the cell door.

The jury found that death resulted from hanging and classified the death as a suicide.

The recommendations of the jury, which were forwarded to the RCMP "E" Division and the Attorney General, were as follows:

1. That procedures should be in place that ensure those individuals flagged as suicidal should be placed in "suicide cells" regardless of their emotional state at the time.

2. That the number of suicide cells be increased.
3. That monitoring procedures of cells be improved, e.g. physically monitoring more frequently.

RESPONSES:

RCMP, "E" Division

1. The Officer in Charge of Burnaby Detachment advises that their entire Guard Manual is currently under review and this recommendation will form policy within the manual.
2. Three cells at Burnaby Detachment are being modified to accommodate potentially suicidal prisoners.
3. Burnaby Detachment has scheduled a second guard for weekday shifts when there is a higher volume of prisoners. One guard is responsible for monitoring of prisoners while the second guard prepares meals, cleans and conducts a variety of other duties. Updates to the Guard Manual also stress the requirement of frequent checks on the monitor, as well as a physical check of prisoners.

Attorney General

1. It is requested that the Commanding Officer of "E" Division advise of any actions that are or will be taken with respect to the jury's recommendations. Police Services Division will also be conducting Municipal Policing Evaluations, which will review detention facilities at independent municipal policing jurisdictions.

INQUEST NO. 21

(CORRECTIONAL FACILITY)

On September 13, 1999, an inquest was held at Victoria, B.C. into the death of a 21-year-old man who died on February 22, 1999, at Vancouver Island Regional Correctional Centre (VIRCC).

The subject was remanded in custody on five counts of break and enter. During a routine inmate count, the subject was discovered hanging in a shower stall at VIRCC.

The jury found that death resulted from hanging and classified the death as a suicide.

The recommendations of the jury, which were forwarded to the Corrections Branch, were as follows:

1. That all seventeen recommendations made by Mr. Anderson of the Attorney General's Investigation and Standard's Report dated March 22, 1999, be implemented immediately.
2. That the existing shower stalls be modified to allow better visibility.
3. That an on-call psychologist be made available on weekends.
4. That an additional phone line be made available as a crisis line for persons with immediate concerns regarding an inmate. These calls should be logged.
5. That all persons answering incoming calls identify themselves.
6. That more inmate information be made available on the CORNET system pertaining to security and medical alerts: e.g. drug abuse, violence etc.

RESPONSES:

1. Action has been taken on all 17 recommendations made by Mr. Anderson in the Attorney General's Investigation and Standards Report.
2. Given the design of VIRCC and the significant cost to retrofit the existing shower stalls, recommendation #2 is not considered to be appropriate or fiscally viable. The Corrections Branch will design future correctional centres with shower stalls that have adequate visibility while still

affording inmates an opportunity for privacy and dignity.

3. A Psychologist is now available on an on-call basis to VIRCC on weekends. VIRCC is reviewing available resources to initiate a mental health screening procedure for all new intakes.

4. Incoming telephone lines are currently recorded. Persons with emergency information can also call 911. Saanich Police have direct contact with the VIRCC

5. A directive has been issued to all staff reminding them of the requirement to identify themselves when answering a telephone.

6. Currently, CORNET allows critical medical, security and behavioural information to be captured and maintained in the ALERTS comments screens. A directive has been issued to all staff reminding them to enter appropriate information on CORNET. Provisions of the Freedom of Information and Protection of Privacy Act limit the publication of confidential medical information.

INQUEST NO. 22

(CORRECTIONAL FACILITY)

On September 14, 1999, an inquest was held at Abbotsford, B.C. into the death of a 70 year-old-male who died on January 8, 1999, at Matsqui, B.C.

The subject was serving a federal sentence at Ferndale Institution. He had a medical history that included Chronic Obstructive Lung Disease and Diabetes. The subject refused medical treatment at hospital and was therefore transferred to Matsqui Institution Health Centre where he died.

The jury found that death resulted from cardiac arrhythmia and classified the death as natural.

The jury had no recommendations.

INQUEST NO. 23

(OTHER)

On October 25, 1999, an inquest was held at Saltspring Island, B.C. into the death of a 55-year-old male who died on January 13, 1999, at Mayne Island, B.C.

On January 13, 1999 a DC3, under charter to Purolater Courier, left Vancouver for Victoria. It was crewed by the subject and a fellow crewman. While travelling straight and level, the plane struck trees near the top of 890 foot Mount Parke on Mayne Island. Parts of the wing were torn off and the aircraft plunged 600 feet vertically and 1100 feet horizontally to a valley below. Both crewman died on impact. The jury found that the cause of death was multiple, extreme injuries due to a plane crash and classified the death as an accident.

The recommendations of the jury, which were forwarded to the Federal Minister of Transport and Navigation Canada, were as follows:

Minister of Transport

1. That Transport Canada pursue with vigour the proposed amendments to the Canadian Aviation regulations (CARS) which would restrict night VFR (Visual Flight Rule) flights of aircraft operating under CARS section 704 and 705.

2. That Transport Canada pursue the requirements of installing ground proximity warning systems (GPWS) in all aircraft operating under CARS 703, 704 and 705.

3. That the safety systems branch of Transport Canada stress, through education, briefings, seminars and other media, the dangers involved in night VFR flight, especially in mountainous terrain and the hazards involved in changing flight plans from instrument flight rules (IFR) to VFR at night.

4. That Transport Canada enact rules that would require pilots of aircraft operating under CARS 703, 704, and 705 file a record of flight indicating whether the flight was VFR or IFR.

Navigation Canada (NAVCAN)

1. That NAVCAN establish a mandatory radio frequency for all aircraft operating VRF in Class E airspace in the Vancouver, Victoria and Nanaimo corridors.
2. That NAVCAN ensure that a minimum safe altitude warning system (MSAW) capability be added to the Canadian Air Traffic Control system as soon as possible.

RESPONSES:

Minister of Transport

1. The June 1999 meeting of the Canadian Aviation Regulation Advisory Council (CARAC) considered Notice of Proposed Amendments (NPA)which proposed a ban on night VFR for CARS 704 AND 705 operations. These NPAs were precipitated, in part, by the Mayne Island accident.
2. With respect to terrain alerting and warning systems (TAWS), Transport Canada is committed to harmonizing its regulations as much as possible, with the U.S. Federal Aviation Administration's TAWS final rule, which will be released soon. Given the number of differences between Canadian and U.S. rules, Transport Canada will need to examine the final version of the U.S. rule once it has been promulgated, to determine how best to apply its provisons to Canadian operators.
3. Transport Canada fully supports recommendation #3. Even though the hazards of night VFR flight are regularly addressed in various promotional activities, such as newsletter articles and education workshops, the department is currently developing a new promotional campaign as a result of the Jury's recommendation.
4. The Commercial Air Service Standards require that 703, 704, and 705 operators establish and maintain an operational control system. Regardless of the level of complexity implemented, an operational control system already contains many checkpoints that specifically reference whether a flight is IFR or VFR or whether or not the flight is operating at night. Pilots are also required to file either an IFR flight plan, VFR flight plan or flight itinerary with an appropriate agency or person. Pilots are expected to comply with the proposed flight plan, including type of flight filed, namely IFR or VFR, unless operational requirements necessitate a change of plans. Should this occur, the pilot is required to communicate the changes to the flight watch authority and the authority with which the flight plan or itinerary was filed. Given the safeguards that are already in place, further regulation in this area is redundant. Transport Canada acknowledges that more can be done to educate operators in this regard, and it is preparing a Commercial and Business Aviation Advisory Circular informing operators and pilots of their responsibility in this area of operations.

NAV Canada

1. It is unclear as to how the recommendations to implement a Mandatory Frequency zone would have assisted in preventing these deaths. NAV Canada will shortly be embarking on a series of system aeronautical studies to examine in detail the air navigation services offered across the country. British Columbia will be one of the systems reviewed.
2. It is not clear that MSAW technology would have contributed to preventing these deaths. The aircraft was operating under a VFR flight plan filed by the aircraft commander. Filing a VFR flight plan indicates that the pilot believed that he could conduct the flight without assistance from Air Traffic Services and that he would be responsible for separation from other aircraft and from

terrain. Minimum Safe Altitude Warning (MSAW) systems are leading edge RADAR technology. NAV Canada is assessing other technologies of this type. MSAW type technology will assist aircraft flying under IFR that do not follow the cleared procedure and venture into unprotected areas.

INQUEST NO. 24

(CORRECTIONAL FACILITY)

On October 28, 1999, an inquest was held at Chilliwack, B.C. into the death of a 38-year-old male who died on January 25, 1999, at Kent Institution at Agassiz, B.C.

The subject had been transferred to Kent Institution from an eastern facility. He had been diagnosed with Adult Attention Deficit Hyperactive Dysfunction. On a routine cell check, the subject was observed hanging by a facility towel from a bar in the cell's closet. Upon his transfer to Kent Institution, the subject was taken off Ritalin by the attending psychiatrist due to concerns with the drug being used as a trafficking substance within the institution. Ritalin was substituted with other medication.

The jury found that the cause of death was asphyxiation due to hanging and classified the death as a suicide.

The recommendations of the jury, which were forwarded to Correctional Service of Canada, were as follows:

1. That when an inmate is transferred from one institution to another, prescribed medications be maintained until after a full assessment by a physician or psychiatrist is completed.
2. That inmate files and information follow inmates from institution to institution immediately upon transfer.
3. That prescribed medications not be withheld because of security concerns. Methods should be developed to administer such medications in a controlled environment.
4. That a written report regarding inmate suicide threats filed be forwarded to every level of supervision and medical care, including any involved outside medical resources.
5. That inmates who have had recent suicide reports filed be visually checked at intervals shorter than standard.
6. That nursing staff be available on site at Kent Institution 24 hours per day.
7. That when outside resources are utilized by an inmate, those outside resources be informed of significant health changes or changes in location of the inmate as soon as possible.
8. That psychological positions at Kent Institution which cannot be filled by permanent staff be filled using outside resources.
9. That additional psychiatric time and resources be made available to the inmates at Kent Institution.
10. That inmate medical files and information be kept in a central location and made available to medical staff, psychiatrists and psychologists, including outside medical resources.

RESPONSES:

Correctional Service of Canada (CSC)

1. When inmates are transferred to Kent from another institution, they now remain on their medication until they are assessed by the physician.
2. All files are sent in accordance with the National and Regional policies. In accordance with the Commissioner's Directive 800 para 41, "Medical and dental records shall accompany the inmate and be

forwarded to the institutional health services immediately upon their receipt."

3. Inmates are prescribed drugs according to the professional judgement of CSC physicians, always keeping in mind the constraints of the correctional environment. When there are security concerns or concerns with compliance, medications are administered in a controlled environment.

4. Psychology suicide risk reports are written immediately following suicide assessments. These reports are entered on an Offender Management System immediately and copies are forwarded to the Correctional Supervisor and to Health Services. Outside psychologists only provide therapy for historical issues such as childhood sexual abuse and are not generally involved with crisis intervention and do not receive copies of these reports. The case is, however, discussed with these psychologists prior to their next interview.

5. Inmates who are assessed as a moderate or high risk are monitored at shorter than standard intervals until the risk diminishes. Inmates who are considered a low risk for suicide are placed on "observe and report" status, but are not visually checked more often than normal. The subject, in this case, was assessed as a low risk for suicide one month prior to his death. No indication of increased suicide risk was seen prior to his suicide.

6. The Correctional Services of Canada eliminated the midnight shift in the majority of institutions across Canada over the past years. This was done as a result of a Management Administration and Operational Review of Health Services initiated in October 1993. Inmates continue to have access to Health Services on a 24-hour basis through on-site coverage, on an on-call basis or through CSC institutions or community services. In institutions where there is no nursing coverage at night, there are always correctional officers trained in First Aid and CPR on site. In cases of emergencies, they are expected to initiate either First Aid or CPR and send the inmate to the local hospital by ambulance.

7. The consent of the offender must be obtained for all medical procedures, psychiatric and psychological assessment and treatment or participation in an form of research and the sharing of health care information. There are limited situations where health care and medical information may be disclosed without consent; i.e. there is reason to believe the offender constitutes a serious or immediate threat to his or her own safety or the safety of others in the institution or community.

8. Since the death of the subject, the staffing situation at Kent Institution has changed. Mountain/Kent Institutions currently have nine indeterminate psychologists. Three psychologists are based at Kent Institution while six are based at Mountain Institution. The Senior Psychologist for these two institutions will ensure that psychological services are available to Kent offenders from the group of nine professional staff.

9. With the indeterminate staffing of psychologists now in place at Kent/Mountain Institutions, Kent inmates will have better access to Psychiatric help.

10. The health care files are located in Health Care. They are available to psychiatrists and psychologists from 0700-2300 hrs. People working in Health Care and Psychological Services have complete access to relevant files.

INQUEST NO. 25

(CORRECTIONAL FACILITY)

On November 4, 1999, an inquest was held at Abbotsford, B.C. into the death of a 43-year-old male who died on January 26, 1999, at Sumas Community Correctional Centre in Abbotsford, B.C.

Sumas Community Correctional Centre is a day parole centre for inmates on a conditional statutory release. The subject was serving a federal sentence and was released on statutory release with residency at Sumas Community Correctional Centre. An inmate obtains statutory release when they have served two-thirds of their sentence. At this time, an inmate must be released to the street unless there are conditions imposed. The subject had a history of illicit drug abuse and had been in a drug rehabilitation program approximately one year prior to his death. The subject was found deceased in his room on a routine check.

The jury found that the cause of death was due to a heroin overdose and classified the death as an accident.

The recommendations of the jury, which were forwarded to Correctional Service of Canada (CSC), were as follows:

1. That CSC implement random weekly searches of inmates person, room and vehicle.
2. That there be closer checks between time away from the Centre for work hours and generally fewer pass hours.
3. That there be more frequent searches of returning inmates by the duty officer.
4. That commissionaire's training include recognizing symptoms of drug overdose in order to have more experience about when to intervene.
5. That there be closer monitoring of Sumas Centre inmates outside the Centre.

RESPONSES:

Correctional Service of Canada

1. Recommendation #1 is accepted and has been actioned. The Standard Operating Policy in effect at Sumas Centre provides that all staff members at Sumas are authorized by CSC to conduct frisk searches of residents, their rooms, and other assigned areas. These searches may be conducted when a staff member believes that the resident is violating or has violated a condition of his conditional release.
2. Recommendation #2 has been accepted and actioned. The current policy with respect to curfews is that residents will be confined to the Center for the first three days. They will then be permitted to leave the property for up to two hours only if in the company of CSC staff or an approved escort until such time as they have completed the Sumas orientation programme. A phased curfew will then be implemented. Offenders will not be out of touch with Sumas Centre for more than eight hours.
3. Recommendation #3 is not accepted in its entirety. Policy in regards to searches requires that there must be reasonable grounds and proper authorization to conduct routine searches of persons. Operating Policy states that every resident, resident visitor, staff member, contractor or volunteer may be subject to a search of their persons or any item carried by them while on CSC property. Residents shall be visually inspected whenever they are sighted. They may be non-intrusively or frisk searched in an instance where such action is reasonable to detect the presence of contraband or unauthorized items.
4. Recommendation #4 is not supported. The Corps of Commissionaires who are employed at Sumas Centre provide very basic functions. Where they suspect that any offender on premises is under the influence of intoxicant or suffering a medical emergency, such as a drug overdose, the Commissionaire immediately summons the on-sight 24-hour duty officer, who is properly trained in responding to such emergency incidents.
5. Recommendation #5 is accepted and has been actioned. Surveillance by Regional Duty Officers and Parole Officers is

ongoing and is required as part of the Intensive Supervision Programme currently in operation in the Fraser Valley District.

INQUEST NO. 26

(CORRECTIONAL FACILITY)

On November 25, 1999, an inquest was held at Chilliwack, B.C. into the death of a 52-year-old male who died on December 20, 1998, at Agassiz, B.C.

The subject was serving a federal sentence at Mountain Institution. Mountain Institution is a medium security federal institution that houses primarily sex offenders and inmates who require protective custody. The institution has a health centre which provides services to inmates that would be similar to what the public would receive from a health clinic. The subject had been found unconscious in the facility shower. First aid was given and the subject was transferred to Chilliwack General Hospital where he later died.

The jury found that the cause death was an acute brain hemorrhage due to hypertension, high blood pressure, and classified the death as natural.

The recommendations of the jury, which were forwarded to Correctional Service of Canada, Mountain Institution and the Registered Nurses Association of B.C., were as follows:

Correctional Service of Canada

1. That regular health care procedures ordered by physicians or nurses be booked by appointment and records kept of attendance.
2. That health care documentation be compiled and maintained in full detail.
3. That guidelines be developed for circumstances in which physician referral or attendance at the institution be required.
4. That all personnel at the institution be trained in the operation of video cameras and all other pertinent equipment.
5. That guidelines be developed to ensure nursing staff monitor compliance on taking medication by inmates.
6. That nurses be on duty at Mountain Institution 24 hrs per day, seven days per week.
7. That all staff be re-certified in CPR yearly.
8. That guidelines be developed to ensure inmates are capable and competent to administer their own medication.

Mountain Institution

1. That this case be reviewed by nursing staff for educational purposes.

Registered Nurses Association of B.C. (RNABC)

1. That a nursing practice consultant review a copy of the verdict and that appropriate action by the RNABC be taken if Nursing Practice Standards have not been met.

RESPONSES:

Registered Nurses Association of B.C.

1. A nursing practice consultant met with representatives from Mountain Institution, Correctional Services Canada and the Coroners Service to review all of the recommendations. As well, a nursing practice consultant will make a site visit to Mountain Institution to offer support for nursing staff in meeting the RNABC Standards for Nursing Practice in British Columbia. This will include follow-up in relation to actions taken to date and the development of additional plans as deemed necessary to ensure staff compliance with practice standards.

No other response has yet been received.

INQUEST NO. 27

(POLICE SHOOTING)

On December 2, 1999, an inquest was held at Kelowna, B.C. into the death of an 18-year-old male who died on January 22, 1999, at Kelowna, B.C.

The RCMP were called to a report of a home invasion in Kelowna, B.C. The subject had ransacked the house and taken cash and credit cards. He then tied the elderly residents and left with their vehicle. The subject then proceeded to a local store where, as he was being pursued by police, he took a hostage at gunpoint. The subject repeatedly fired shots at police. The RCMP, believing that a member had been shot and fearing the safety of the hostage, fired their weapons. The subject sustained four gunshot wounds, two of them fatal.

The jury found that the cause of death was multiple gunshot wounds to the head, chest and abdomen and classified the death as a homicide.

The jury made no recommendations.

INQUEST NO. 28

(CORRECTIONAL FACILITY)

On December 7, 1999, an inquest was held at Abbotsford, B.C. into the death of a 59-year-old male who died on February 10, 1999, at Matsqui, B.C.

The subject was serving a federal sentence at Mission Medium Security Institution. He was diagnosed as having symptoms suggestive of lung cancer. He was transferred to Regional Hospital at Matsqui Institution where his condition continued to decline.

The jury found that the cause of death was advanced cancer and classified the death as natural.

The jury made no recommendations.

INQUEST NO. 29

(CORRECTIONAL FACILITY)

On December 14, 1999, an inquest was held at Chilliwack, B.C. into the death of a 22-year-old male who died at Agassiz, B.C.

The subject was on statutory release and was being retained in the Temporary Detention Unit (TDU) at Kent Institution. The inmates in this unit have no contact with inmates in the general population. It is an open unit with unrestricted movement within the unit itself. The subject was found unresponsive in his cell with no carotid pulse.

The jury found that the cause of death was acute heroin overdose and classified the death as an accident.

The recommendations of the jury, which were forwarded Correctional Services of Canada (CSC), were as follows:

1. That standard procedure throughout the prison system be administration of CPR to inmates regardless of personal comfort with person/CPR.
2. That every correction officer take CPR training.
3. That Narcan be used in any cases of suspected drug overdoses.
4. That the TDU develop better communication among staff, specifically walkie-talkies or CB or radios.
5. That food trays be thoroughly checked for drugs by both officers together.

RESPONSES:

Correctional Services Canada

1. The Service's First Aid protocol dictates that a first aid responder must first ensure his or

her own safety prior to rendering first aid. Security procedures dictate that a staff member should not enter an inmate's cell alone, as to do so could cause undue risk to their safety. Safe practice in this situation would require the responding staff member to secure adequate back up prior to entering an inmate's cell to administer first aid.

2. Current CSC policy requires 30 percent of Correctional Officers at the institution to be trained in CPR on a yearly basis.
3. The subject was not breathing when the nurse arrived on the scene. As the subject did not respond to CPR, Narcan would have been of no use.
4. All correctional staff working in the TDU are provided with personal portable alarms, which they may activate in cases of emergency. Every cell has a cell call "button" which may be activated by an inmate requesting assistance. The correctional officer assigned to the unit control post has a radio and telephone that is linked directly to the main communication control post.
5. The food trays used in the Segregation and TD Units are prepared by food service officers in the kitchen and then placed on food carts. The food carts are moved to these units under staff supervision and security staff inspect the carts upon arrival in the respective units. This inspection includes a visual check of each food tray. To have the security officers physically examine the contents of each food tray before serving to inmates would add little to security and lead to continuous complaints and possibly confrontation from inmates, over cold or allegedly tainted food.

CONTACT INFORMATION

For more information or additional copies of this report, please contact:

Office of the Chief Coroner
Suite 2035 - 4720 Kingsway
Burnaby, BC V5H 4N2

Tel: (604) 660-7746
Fax: (604) 660-7766